Term Life Coverage Continuation Request

ReliaStar Life Insurance Company
A member of the ING family of companies
PO Box 20, Minneapolis, Minnesota 55440

Instructions

Employer: Read the policy/certificate carefully to determine which coverage(s) are eligible for continuation. Complete and sign the first page of this form. Send this form along with copies of original enrollment/application form(s) to the employee to complete. If your plan provides separate policies or certificates for spouses, then employee and spouse information must be completed on separate forms, with the spouse form to be sent along with copies of original spouse enrollment/application form(s) to the spouse to complete.

Employee (or Spouse): Complete the employee/spouse section on the second page and return the form to the address shown. Be sure to include copies of enrollment/application form(s) indicating coverage amounts and beneficiary designations as well as your first quarterly premium. **Coverage will not be continued without this information.** We must receive this form within 31 days of the date premium is paid as shown on this form.

This section to be completed by employer

Insured Employee (or Spouse) Information

Employer or group name	Policy number(s)	Account number	Date payroll deduction terminated	Annual Salary at Termination
State of North Carolina				

Insured name	Social Security No.	Date of birth	Date of hire	Is direct billing the result of a disability? ❒ Yes ❒ No

Employee Name (if other than insured):

Date Voluntary Life effective	Date Voluntary Life premium paid to	Reason for Continuation: ❒ Unpaid LOA ❒ Employment Terminated

Coverage type	Coverage Amount at termination	(1) Coverage Amount eligible for continuation	(2) Monthly premium rate per $1,000	Quarterly premium due (coverage x rate x 3)
Employee Voluntary Life				
			Total	

Dependent Information

Date dependent coverage effective	Date dependent premium paid to	Spouse Name	Spouse Date of Birth	Spouse Social Security No.

Coverage type	Coverage Amount at termination	(1) Coverage Amount eligible for continuation	(2) Monthly premium rate per $1,000 or per unit	Quarterly premium due (coverage x rate x 3)
Dependent Spouse Voluntary Life				
Children Voluntary Life				
			Total	

(1) Coverage at termination limited by the maximum coverage that can be continued.
(2) For supplemental and dependent coverage, premium rates for continuing coverage will typically stay the same as for active employees; however are subject to future increases. For basic life and AD&D, premium rates for continuing coverage will be provided to the employee by the employer.

Quarterly Premium Due

Quarterly premium due (total of insured employee (or spouse) and dependent premium above)	**$**_____
Quarterly billing charge	**+ $** **3.50**
Total payment required with this form (Insured + Dependents)	**$**_____

Signature of employer representative	Date	Company telephone number

This section to be completed by employee/spouse

Billing address *(Street, city, state, zip)*

Enclosed with this form is my first quarterly premium made payable to ReliaStar Life Insurance Company. I hereby authorize ReliaStar Life to begin billing me directly for my Term Life Insurance coverage.

Date	Your signature

Mail to: NC Flex
PO Box 492517
Redding, CA 96049-1850
Fax: 530-223-7712

QUESTIONS? Call NC Flex @ 1-877-464-5111.

This section to be completed by ReliaStar Life

Date received	Renewal date	Group number	Certificate number	Date mailed